Before the
Federal Communications Commission
Washington, D.C. 20554

In the. Matter of	)	
	)	
Promoting Telehealth for Low-Income Consumer	)	WC Docket No. 18-213
	)	
	)	

COMMENTS OF SAGE TELECOM COMMUNICATIONS, LLC
D/B/A TRUCONNECT IN RESPONSE TO
NOTICE OF INQUIRY ON TELEHEALTH AND
PROPOSED CONNECTED CARE PILOT PROGRAM

I. INTRODUCTION.

Sage Telecom Communications d/b/a TruConnect ("TruConnect"), by counsel, pursuant to the Federal Communications Commission's ("FCC" or the "Commission") Notice of Inquiry ("NOI") released by the Federal Communications Commission on August 3, 2018, WC Docket No. 18-213, relating to an experimental Connected Care Pilot Program and hereby submits these comments:

TruConnect recommends the following objectives to and focus for the Connect Care Pilot Program ("Pilot" or "Pilot Program") and submits proposed answers to questions and responses to comments made in the Notice of Inquiry seeking public input on issues such as the pilot program's structure, eligibility for participation, accountability measures, legal authority to act and state barriers to overcome.

II. OVERVIEW OF TRUCONNECT COMMENTS.

This telehealth pilot program is a very important initiative. The government has a role creating the most favorable environment and incentives to meet the need to more quickly advance telehealth services to improve healthcare delivery and access to world-class healthcare for all American's. This is about savings lives and saving money for patients, providers and taxpayers. There are many issues to explore and lessons learned from prior government telecommunications initiatives in order to design a worthwhile and effective pilot program. The method of connectivity (broadband, wireless, and fixed, or mobile), incentives

to offer, the stakeholders to include, program design and eligibility are important as well as defining what the Commission seeks to accomplish for a pilot program because it is all important to "get right". This Connect Care Pilot Program should not use taxpayer USF funds to do what the private sector can do with the right incentives, similar to how our country encouraged the build out of electrical power across rural America over 75 years ago.

Furthermore, telehealth initiatives like those contemplated and needed require changes in state laws to address legal barriers, to increase reimbursement payments, to grant authority for providers, and to grant permission to access patients' personal health information in this context. The Commission must also consider what type of infrastructure buildout should be incentivized in this pilot program (if any), how and who pays for the infrastructure buildout, interconnectivity and interoperability of software communications between physicians and patients, funding models, accountability of federal funds, possible equipment funding for physicians, hospitals, clinics or patients, etc.

III. PILOT PROGRAM STRUCTURE AND ELIGIBILITY.

Since time and funds are somewhat limited for a pilot, the Commission should first determine if the pilot program should attempt to jointly focus on both broadband and wireless, fixed or mobile, or should the pilot focus on only one method of service delivery. Limiting the pilot program in this way could later require creating a separate pilot for the alternative. That, however, may be a wiser focus of this initial pilot due to limited time and funds. Moreover, a narrower focus will improve the likelihood that the results and data will help the Commission assess future opportunities since funds are not spread too thin. We suggest that a broadband pilot program will require more time, funding, and infrastructure build-outs than a mobile wireless-based pilot in order to obtain worthwhile results and data.

Several broadband infrastructure specific issues also exist for a broadband based pilot, for example the pilot may require: more than 2 to 3 years since needed infrastructure buildouts take time and must be designed and permitted at the local level; more expensive devices, software and training to serve

participants especially in a temporary pilot that includes video conferencing capabilities; telecommunications services and data speeds to increase through infrastructure improvements and build-outs; medical licensing, and state barriers to overcome. Wireless services will likely require some infrastructure upgrades and build-outs in more rural areas, however, wireless connectivity should be more available there than cable or microwave-based services which are necessary to deliver video-based telehealth services. Also, many of the other above referenced issues can be avoided using wireless based healthcare technologies.

The Pilot Program should include as many types of modalities as practical and deemed efficient with limited time and pilot funding, especially if funds are distributed amongst multiple participants. In other words, equipment is expensive, and infrastructure is both expensive and time intensive. We recommend a narrower focus that includes an array of participants from different groups such as facilities and non-facilities based ETCs to increase the number of proposals, to maximize use of funds and to produce multiple outcomes for analysis. The pilot eligibility requirements should not restrict the type of existing infrastructure used. For example, it should not be limited to facilities-based ETCs if the focus is on low-income individual patients. Primarily non-facilities based ETCs have served these low-income populations. Larger facilities based ETCs have focused on other populations where margins are higher and perhaps administrative costs are less. To Commissioner O'Rielly's point in the NOI, existing FCC approved programs should be included since clear authority and Commission infrastructure exists. Commissioner O'Rielly's comments should be strongly considered especially recognizing the limited time and available funding.

A. PILOT PROGRAM INCENTIVES.

The incentives created in the pilot must align with its focus and goals. The preferred method to incent government supported expensive and complex initiatives in which the public sector has expertise and operates are public private partnerships. They best align the interests of participants which receive

funds for services they provide. The Commission should establish clear qualifications for companies to participate and be eligible to receive federal funding. Qualifications should include proven telecommunications or healthcare experience, financial stability and some track record serving the targeted individuals with either healthcare or telecommunications-based services. The Commission should also consider requiring corporate participants to contribute perhaps 30 percent of the gross cost of their approved project to be matched with pilot program funds. This will enable the FCC to select more participants offering different types of proposals from different geographic regions and using different technologies. You may wish to use a sliding match scale dependent upon the financial size of the participating company or healthcare provider. The Commission should also encourage joint venture or partnership type arrangements between eligible participants to leverage expertise, technologies and improve outcomes. If a JV or partnership will be developed, it should be disclosed, and they should file a joint application or otherwise detail their joint efforts and delineate their proposed use of funds and the elements of their proposal. Neither the Commission nor this pilot has time for those arrangements to be made after being designated and funded.

Including hospitals, or too many hospitals, in a limited pilot may not wisely utilize funds since the infrastructure and equipment needs to support multiple hospitals as well as incent them to participate in a temporary program may not be attractive. A hospital-based initiative likely contemplates video conferencing thus the support and infrastructure needs become costly and complex for a pilot unless that's all the pilot is designed for.

Also consider that a successful pilot may not actually require lots of funding for telehealth technology device applications. For example, if the Lifeline program is included, those ETCs may likely include telehealth applications on devices at very low costs especially if a port freeze is set and providers can expect reimbursements for their equipment investment because the participant stays with them for the requisite time period.

It is also wise to ensure that the geographic focus is consistent with the pilot's objectives and reality of a time and funding for a limited program. This should not be a telehealth pilot to encourage telehealth in general but a program to discover viable and effective initiatives and program designs to possibility incorporate into a more permanent program designed to improve connectivity and healthcare access for people in areas that lack it. The pilot should focus on unserved areas and tribal lands across the country where viable access to healthcare has been poor for years. In these areas people have worse access to healthcare. The areas can be identified by researching census blocks to determine low broadband and wireless adoption areas coupled with demographics. If the pilot is limited to these areas, then it can be used to truly learn and explore most everything that is needed to effectively deliver world class healthcare to those areas with that technology delivery method, i.e. wireless or broadband fixed or mobile. Furthermore, statistics reveal that the populations in these areas tend to have higher rates of diabetes, heart disease, obesity and other related health issues. Improving access to care and continuity of care for those residents is very beneficial.

We know that the use of telemedicine applications on smartphones and devices benefits those who use them and will especially help rural patients who must travel great distances to healthcare providers. Many do not and cannot afford to do so. Also, lower income Americans such as those currently eligible for government programs should be included in this pilot, perhaps solely. They can be fairly easily identified. Moreover, this demographic has more challenges accessing healthcare because they cannot afford it, live too far away, or both. Telehealth may provide the greatest benefit for these individuals. Narrowing the focus will help make the pilot successful.

Although video conferencing requiring broadband at higher speeds is very useful, the first step should be to incent mobile based remote type healthcare application uses since the overall costs for equipment, infrastructure, etc. are lower. Thereafter, best practices for the government's involvement in this delivery method can be developed based on the pilot data.

If under-served or served area across the country are included, then time and moneys do not allow a temporary pilot program to achieve much. It also opens the door for criticism and may not provide worthwhile results or data for the Commission to consider when creating a permanent program. This does not mean that those areas have viable telehealth services; it merely reflects the reality of implementing a pilot program with an objective to create the best test model to gather beneficial information for later use. In addition, the Commission may not have legal authority to support federal funding for served areas and to companies and individuals residing there.

It's important to remember that a pilot is temporary. If video telehealth is the established focus of this pilot program, then higher data speeds and bandwidth is required to be effective. It is not wise to mandate minimum data service speeds that are funded (fully or partially) by the government when the private sector has not done so already for a variety of relevant business reasons. Establishing a minimum service standard in this pilot will detract from the broader focus of the pilot. It would also require continued, not short-term pilot, subsidies to increase data speeds across rural America in order to make the new equipment effective. Sustaining such a permanent initiative is very costly for taxpayers to fund. That objective is best suited for a more permanent public private partnership program and not a pilot. Therefore, we recommend focusing this pilot on wireless connectivity and existing telecommunications devices and technologies to increase the likelihood of success and qualifiable data. Thereafter, a second pilot and or larger joint federal agency program can be explored involving infrastructure and other telecommunications initiatives arguably within the jurisdiction of sister federal agencies.

Direct customer subsidies should not be allowed. Providing funds directly may violate federal law and creates a plethora of accountability, fraud and abuse issues that can all largely be avoided. Company recipients of funds are better suited to report and track funds than requiring and expecting that every individual will self-report receipts, purchases etc. Furthermore, it would take years to market and share with people that a temporary pilot exists, to teach them how to apply and then set up systems to track and

account for the use of individual funds. In addition, the government does not have authority to directly fund devices, software, equipment, etc. nor authority to fund equipment and software updates, account and replace lost, stolen and damaged equipment, etc.

If such a direct funding plan is allowed, then the pilot must also include a port freeze requirement of perhaps 6 months to discourage recipients from selling the device or obtaining devices from multiple providers at the same time. Port freezes also enable the device provider and government to keep better track of equipment, participants' eligibility, and essentially precludes a participant from having more than one device. Stability with a port freeze also makes it easier to monitor the use of each device and enforce accountability measures. Without a port freeze in place, eligibility verification will be challenging with frequent switching very costly to the program and Commission. The majority of those costs can be avoided.

Nor should direct payments be provided to eligible individual participants to help offset the cost of their device purchase. It is very challenging to ensure direct payments are spent as required. Numerous problems are created with direct payments very similar to the waste, fraud, abuse and criminal activity prevalent in the federal foods stamp program. For these reasons, a port freeze should be included in any telehealth program. This program is not the free market where a customer makes purchase decisions based on price and product because the economic incentives do not exist for essentially free products. If funds are distributed to the corporate participants and they are required to provide devices, then their financial risk will help ensure that the devices are used as the program requires. Furthermore, infrastructure development, deployment and funding of computers, software, laptops, smartphones is not the government's role. Necessary funding for development and device purchases and updates cannot be sustained. Thus, sustainability of any "program" created by this pilot should be considered and fully explored.

The NOI also asks for comments about how to prevent possible overbuilding. One point to remember is that it is not the government's responsibility to fully fund telecommunication infrastructure build out and deployments. A healthy telecommunications private sector exists. This pilot can and should be designed to explore optimal methods to create an environment that incents build outs similar to the type of regulatory environment the FCC is advancing with its infrastructure site permitting regulations like the "shot clock", or to not impede infrastructure development with state taxes on the very infrastructure required to build the network to provide services.

B. PILOT PROGRAM JURISDICTION.

To prevent duplication or acting outside the Commission's authority, the FCC should work to develop a coordinated pilot or more permanent program with another agency after this more limited pilot concludes. The broadband stimulus initiative implemented through USDA Rural Utilities Service ("RUS") agency and National Telecommunications and Information Administration ("NTIA") provides many valuable lessons to either use or avoid. Funds were wasted, and very little sustainable infrastructure survives. That program should be closely examined and perhaps the FCC should emulate best practices learned.

Several other federal agencies also claim jurisdiction over broadband and telecommunications. They have initiatives to build-out rural broadband infrastructure and to encourage digital communications. RUS, NTIA and US Health & Human Services Departments Digital Communications Division ("DCD") are involved and have such programs or ongoing initiatives. In designing this pilot, the existing FCC programs and initiatives, like Lifeline, should be prioritized and used in this pilot to insure the Commission operates within the law. It may be possible to develop a multi-agency pilot later similar to the broadband stimulus BTOP and BOP initiatives (but one that works) if a broader joint program is desired.

The FCC may not have legal authority to provide infrastructure funds to selected private sector companies; nor the necessary manpower and technical capabilities to accurately track and enforce

accountability measures necessary for this pilot. Some would also argue that a pilot program in which funds were by and large wasted or if the pilot is deemed to have failed because it was either to broad or too "aggressive" for a temporary pilot may consequently embarrass the Commission and may set back FCC sponsored telehealth initiatives. No one wants that result.

Therefore, a Pilot Program should not and cannot appear to be a full-blown program, neither by intent or by design or a scope that is too broad. This pilot does or cannot provide enough funds to truly satisfy the collective need and aggregate cost. Therefore, the focus should be narrow with a follow up pilot contemplated to explore related initiatives that are not suited for just one pilot. Also, keep in mind the larger FirstNet program to build out public safety telecommunications infrastructure is funded with over $5 billion of federal funds. Most experts believe that that actual amount needed to meet their proposed objectives is over 10 times that amount. For these reasons, a telehealth program, as suggested in the NOI, is best suited for a combined pilot with other agencies that have existing legal jurisdiction, authority, experience and staffs to support a broader program. Therefore, to truly achieve the pilot's objectives a joint agency initiative should be explored. This said, an FCC based pilot designed narrowly with stated achievable objectives can be highly successful.

C. ELIGIBILITY.

In order to be eligible for this pilot corporate participants should show prior experience providing telecommunications or telehealth related services. They should have the financial capability to match federal funding as should be required, and they should have the infrastructure in place to deliver the intended services. Corporate participants should be allowed to partner with each other formally or informally to create an application to participate in the pilot to advance a broader or more robust initiative. As stated previously, the pilot should focus exclusively on low-income Americans such as those eligible for current government-based programs like Medicaid and the veteran's programs for those who qualify

for cost-free healthcare through the Department of Veterans Affairs. The FCC should remember that not every eligible American sign up for federally eligible programs.

The same federal eligibility and on-boarding technologies and procedures should be used because they are proven to work and screen out non-eligible applicants. Yes, some people slip through and waste, fraud and abuse exist in those programs as well. However, their one-step eligibility verification system technologies work and should be used by corporate participants so long as databases can be readily accessed to ensure eligibility. Time is limited in a pilot so if the on-boarding process is slow, multifaceted or cumbersome many targeted individual pilot program participants may not be reached or served. The quantitative and qualitative data will reflect that flawed result.

And, all recipients of federal funds should be required to report quarterly or semi-annually on: how they use funds, their progress, and the number of individuals they serve. We do not recommend that this pilot directly fund individuals. If the pilot program does provide direct funding, it must individually track and verify the use of those moneys to ensure they are all used as intended and benefit those intended. Direct funding of individuals creates massive opportunities for theft, fraud waste and abuse. Accountability and enforcement measures are important to include to avoid wasting millions of dollars like the referenced RUS and NTIA which only produced short-term benefits.

IV. STATE BARRIERS TO OVERCOME.

States have erected numerous barriers to practicing medicine if an individual does not hold that state's license. These barriers limit providers coming across state lines to deliver healthcare including examining, treating and prescribing for patients using most telehealth technologies without that states' authority. States also establish limits on authorized scopes of practice for healthcare providers. These differ from state to state. In addition, many state Medicaid programs restrict or reduce reimbursements for telehealth services as do many private health insurance companies. It will take quite some time to pass necessary changes in states across the country. The issues are controversial and have strong opponents to

scope of practice and open license initiatives. The greatest barriers may actually exist in medical practices and provision of services such as are available through video broadband based medical technologies. The same barriers do not exist for portable or remote monitoring devices or with many smart phone applications used to track and report on blood sugar levels for diabetics, heart monitors, blood glucose levels, blood pressure, etc. Demonstration type videos can be transmitted wirelessly often requiring less bandwidth than two-way video-based communications. Wireless connectivity is still needed to make these useful but massive infrastructure build-outs are not needed and not as important to make a successful pilot. Furthermore, much greater use of remote monitoring devices and communications with in-state providers produces better health outcomes and continuity of care.

Another barrier lies in the cost and training to incorporate telehealth services into a physician or hospital-based medical practice. To fully outcome this hurdle not only must reimbursements increase, one must also consider real issues like funding for necessary equipment and technology, equipment reliability, technical training for physicians and care providers, expensive IT support and software updates, patient privacy, security of electronic data, HIPPA security issues, interoperability of virtual healthcare technologies with existing physician software (which varies among specialties), possible increased medical errors, required new hospital privileges to deliver care, medical malpractice insurance coverage for telehealth, etc. And, the healthcare provider must believe it's worth their time and expense to incorporate telehealth services in their delivery of care.

Another important consideration is maintaining the security of patient information and records when using telemedicine technologies. Current laws, including HIPAA and other laws and regulations, and enhanced data security measures must be followed. All pilot program participants, both healthcare providers and individual patients, should be clearly notified of this requirement and the risk. Patients should be clearly notified that their personal information may be shared with other healthcare providers similar to when they actually visit a healthcare provider. They should be required to acknowledge and authorize

sharing of their medical records. Recipients and hosts of the data should also insure that have appropriate secure means to access and store this data. Accountability measures should be put in place providing periodic checks.

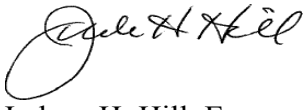
To truly help advance telehealth, states and the federal government should: explore legislative and regulatory changes that improve access to healthcare, increase consistency in medical coverage, expand and increase federal, state and private payer reimbursements for telehealth services, loosen restrictions on the circumstances under which telehealth services can be provided and incentivize providers to participate in delivering care to patients via a broad range of telehealth technologies. The existing barrier issues are complex, require time and can be expensive to resolve.

V. SUMMARY.

The wise use of new technology has the potential to dramatically improve both access to healthcare and the quality of care in rural communities. A test pilot program that is too broad in scope will not allow enough time or offer enough financial incentives, especially long term, to encourage participation in the pilot nor to incent greater use of telehealth or integration into physicians and hospitals healthcare delivery systems. A pilot program that is not narrowly targeted and just offers temporary funding will be seen as such and may not attract the participants that are needed to complete an effective telehealth pilot program, nor would it provide quality data for the Commission's use to design a permanent program. For these reasons and those stated above, we applaud the Commission initiating a telehealth pilot program and recommend consideration and incorporation of our comments into the design of the final telehealth pilot program(s).

Pursuant to section 1.415 and 1.419 of the Commission's rules, these Comments are being filed electronically.

Respectfully submitted,



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